Senate Bill No. 981

Passed the Senate August 31, 2008

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Secretary of the Senate

Passed the Assembly August 27, 2008

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2008, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add and repeal Sections 1371.42 and 1379.1 of, and to add and repeal Article 5.57 (commencing with Section 1374.40) of Chapter 2.2 of Division 2 of, the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 981, Perata. Health care coverage: noncontracting emergency physician claims.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the payment of provider claims and the resolution of claim disputes, as specified, and requires health care service plans to ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claim disputes. Existing law establishes an independent medical review system in which requests for review of disputed health care services, as defined, are conducted by an independent medical review organization.

Existing law also requires plans to provide subscribers and enrollees basic health care services, including emergency services, and requires plans to reimburse providers for emergency services and care provided to enrollees, except as specified.

This bill would enact various provisions applicable to noncontracting emergency physicians, as defined. The bill would require that payment for each coded and charged covered emergency medical service rendered by a noncontracting emergency physician be made at the lesser of the physician's full charge or the interim payment standard, as specified. The bill would authorize the physician to file a complaint with the department if a health care service plan or its contracting risk-bearing organization underpays or fails to make that payment and would require the department to investigate the complaint, make a determination within a specified time period, and, if the complaint is substantiated, take appropriate enforcement action

and require the plan or its risk-bearing organization to make specified payments. The bill would enact other related provisions.

This bill would also prohibit a noncontracting emergency physician from seeking payment from individual enrollees for covered emergency medical services he or she rendered, except for allowable copayments and deductibles, and would require the physician to seek reimbursement solely from the enrollee's health care service plan or the plan's contracting risk-bearing organization. The bill would require a health care service plan that becomes aware that one of its enrollees has been billed in violation of these provisions to report that violation to the department. The bill would also provide that an enrollee shall have no obligation to pay an amount billed in violation of these provisions.

In addition, this bill would require the department to take all steps necessary to establish an Independent Dispute Resolution Process by July 1, 2009, and would authorize noncontracting emergency physicians, as defined, or health care service plans or their contracting risk-bearing organizations to seek review of noncontracted claim payment disputes, as defined, by that process, as specified. The bill would require that an independent dispute resolution organization administer the Internal Dispute Resolution Process, as specified, and issue determinations within specified time periods. The bill would, among other things, require the organization to apply a specified standard regarding claim reimbursement and would require the department to submit a report to the appropriate policy and fiscal committees of the Legislature on or before January 1, 2011, on the adequacy and effectiveness of that standard, as specified. The bill would also require the department to collect information about the results obtained from the process and report annually to the appropriate fiscal and policy committees of the Legislature. In addition, the bill would require the department to issue a final report on or before January 1, 2013, regarding the effectiveness of the process, among other things. The bill would enact other related provisions.

The bill would make its provisions operative when the department adopts the interim payment standard as specified, and the director of the department declares the establishment of the Independent Dispute Resolution Process, and would repeal those provisions on December 31, 2013; however, the bill would specify that its provisions shall not become operative if the department

fails to take those actions by July 1, 2009. The bill would also prohibit the construction of its provisions to modify state or federal laws or regulations that prohibit balance billing of Medi-Cal beneficiaries or alter noncontracted rates.

Because the bill would specify additional requirements for health care service plans, a willful violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. (a) It is the intent of this act to protect enrollees of health care service plans from being billed when the plans, or their contracting risk-bearing organizations, and noncontracting emergency physicians dispute the amount of a claim.

(b) It is further the intent of this act to establish a fair, fast, and cost-effective dispute resolution process, administered by an independent third party and overseen by the Department of Managed Health Care, for the resolution of claim payment disputes between noncontracting emergency physicians and health care service plans, or their contracting risk-bearing organizations.

SEC. 2. Section 1371.42 is added to the Health and Safety Code, to read:

1371.42. (a) This section shall govern the payment of complete claims, as described in Section 1371.35, submitted by noncontracting emergency physicians for covered emergency medical services provided to plan enrollees.

(b) Except as provided in subdivision (c), payment for each coded and charged covered emergency medical service rendered by a noncontracting emergency physician shall be made in accordance with the proper coding and bundling standard identified in subdivision (b) of Section 1374.43 and with applicable provisions of this chapter, and shall be paid at the lesser of the physician's full charge or the interim payment standard, less allowable copayments and deductibles that are the responsibility

of the enrollee. Alternatively, a health care service plan or its contracting risk-bearing organization may pay for that service in an amount that it believes reflects the reasonable and customary value of the service and that is no less than the interim payment standard.

(c) A health care service plan or a health care service plan's contracting risk-bearing organization shall not down-code Current Procedural Terminology codes when making a payment at the interim payment standard pursuant to this section.

(d) Notwithstanding subdivision (b), payment of a claim at the interim payment standard pursuant to this section shall be construed only as an initial payment that may or may not be determinative of the reasonable and customary value of the service rendered. A noncontracting emergency physician's acceptance of a payment at the interim payment standard pursuant to this section for a service rendered shall not constitute an agreement by the physician that the claim for the service has been satisfied. In addition, a payment by a health care service plan or its contracting risk-bearing organization at the interim payment standard pursuant to this section shall not constitute an agreement by the plan or the risk-bearing organization that the claim should be paid at the interim payment standard.

(e) If a health care service plan or a health care service plan's contracting risk-bearing organization underpays or fails to make a payment as provided in this section, the noncontracting emergency physician may file a complaint with the department. The department shall investigate the complaint and make a determination within 60 days of receipt of the complaint. If the complaint is substantiated, the department shall take appropriate enforcement action and require the plan or the plan's contracting risk-bearing organization to do both of the following:

(1) Pay the noncontracting emergency physician the amount of the underpayment.

(2) Pay the noncontracting emergency physician an amount equal to the cost of submitting a complaint to the department, not to exceed twenty-five dollars ($25).

(f) After making or receiving a timely payment at no less than the interim payment standard pursuant to this section, the noncontracting emergency physician, the health care service plan, or the health care service plan's contracting risk-bearing

organization may seek an adjustment of that payment through any available processes, including, but not limited to, the department's Independent Dispute Resolution Process pursuant to Article 5.57 (commencing with Section 1374.40).

(g) A health care service plan or its contracting risk-bearing organization shall not attempt to recover an adjustment to the payment of a noncontracting emergency physician made pursuant to this section unless and until the department's Independent Dispute Resolution Process, under Article 5.57 (commencing with Section 1374.40), or a court of law issues a determination that requires that adjustment.

(h) For purposes of this section, the following terms have the following meanings:

(1) "Covered emergency medical service" shall have the same meaning as "emergency services and care" as defined in Section 1317.1.

(2) (A) "Interim payment standard" means 250 percent of the January 1, 2007, published Medicare rates for services provided by emergency physicians by region in California.

(B) The department shall adjust the interim payment standard to reflect changes in the Medical Care Professional Services component of the Western Urban Consumer Price Index (CPI) for the period from the effective date of the rates described in subparagraph (A) to the operative date of this section. If the CPI for this period is not available, the most recent CPI shall be used with the adjustment period changed to reflect the number of months between the effective date of the rates described in subparagraph (A) and the operative date of this section.

(C) The department shall adjust the interim payment standard in the manner described in subparagraph (B) every 12 months following the first adjustment described in subparagraph (B).

(D) The department shall, by regulation, adopt an interim payment standard for new Current Procedural Terminology codes recognized for payment by the federal Medicare program within 60 days of that recognition. The amount of the new interim payment standard shall be established by using the same or similar Total Relative Value Unit in the Medicare rates specified in subparagraph (A), increased by CPI adjustments pursuant to subparagraphs (B) and (C).

(E) Notwithstanding any other provision of this paragraph, the interim payment standard for services provided to enrollees of the Healthy Families Program shall be 125 percent of the Medi-Cal fee schedule rate.

(3) "Noncontracting emergency physician" means an emergency physician, as defined in Section 1379.1, who does not have a contract with a patient's health care service plan or the health care service plan's contracting risk-bearing organization to provide health care services to the patient.

(4) "Risk-bearing organization" shall have the meaning set forth in subdivision (g) of Section 1375.4.

SEC. 3. Article 5.57 (commencing with Section 1374.40) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 5.57. Independent Dispute Resolution Process

1374.40. (a) A noncontracting emergency physician, a health care service plan, or a health care service plan's contracting risk-bearing organization may seek review of a noncontracted claim payment dispute through the Independent Dispute Resolution Process pursuant to this article.

(b) The Independent Dispute Resolution Process shall be administered by an independent dispute resolution organization that contracts with the department pursuant to Section 1374.415.

(c) The department shall seek assistance and advice in the implementation of this article in equal portions from billing and payment experts representing noncontracting emergency physicians and from billing and payment experts representing health care service plans and their contracting risk-bearing organizations.

1374.41. For purposes of this article, the following terms have the following meanings:

(a) "Covered emergency medical service" shall have the same meaning as "emergency services and care" as defined in Section 1317.1.

(b) "IDRP" means the Independent Dispute Resolution Process established by this article.

(c) "Noncontracted claim payment dispute" means a dispute between a noncontracting emergency physician and a health care service plan or a health care service plan's contracting risk-bearing

organization as to the reasonable and customary value of covered emergency medical services rendered by the physician.

(d) "Noncontracting emergency physician" means an emergency physician, as defined in Section 1379.1, who does not have a contract with a patient's health care service plan or the health care service plan's contracting risk-bearing organization to provide health care services to the patient.

(e) "Organization" means the independent dispute resolution organization that contracts with the department to administer the IDRP pursuant to Section 1374.415.

(f) "Risk-bearing organization" shall have the meaning set forth in subdivision (g) of Section 1375.4.

1374.415. (a) The department shall contract with an independent dispute resolution organization to administer the IDRP pursuant to this article.

(b) The organization shall meet all of the following requirements:

(1) Be independent of any health care service plan, risk-bearing organization, or organization of emergency physicians doing business in this state.

(2) Not be an affiliate or a subsidiary of, or in any way owned or controlled by, a health care service plan, a physician, or physician group, or a trade association of health care service plans, physicians, or physician groups. A board member, director, officer, or employee of the organization shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health care service plan or a trade association of health care service plans shall not serve as a board member, director, officer, or employee of the organization.

(3) Submit to the department the following information upon initial application to contract with the department for purposes of this article and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars ($100,000), if any.

(C) The names of all corporations and organizations that the organization controls or is affiliated with, and the nature and extent

of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care organization, provider group, or board or committee of a health care service plan, managed care organization, or provider group.

(E) A description of the dispute resolution process the organization proposes to use, including, but not limited to, the method of selecting dispute resolution experts.

(F) A description of how the organization ensures compliance with the conflict-of-interest requirements of this section and any other conflict-of-interest requirements imposed by the department pursuant to subdivision (d).

(c) The organization, any experts it designates to conduct dispute resolution, or any officer, director, or employee shall not have any material professional, familial, or financial affiliation, as determined by the director, with any of the following:

(1) A health care service plan.

(2) Any officer, director, or employee of a health care service plan.

(3) A physician, a physician's medical group, or the independent practice association involved in the covered emergency medical service in dispute or any entity that contracts with a physician, a physician's medical group, or the independent practice association to provide billing services regarding the covered emergency medical services, including, but not limited to, coding of claims, determination of the amount that should be paid on claims, billing and collecting fees, or negotiating claims.

(d) The director may establish additional requirements, including additional conflict-of-interest standards not specified in this section, consistent with the purposes of this article, that the organization shall be required to meet in order to administer the IDRP and to assist the department in carrying out its responsibilities.

(e) The department shall provide, upon the request of an interested person, a copy of all nonproprietary information, as determined by the director, filed with the department by an organization seeking to contract with the department to administer

the IDRP pursuant to this article. The department may charge a nominal fee to the interested person for photocopying the requested information.

(f) For purposes of this section, the following terms have the following meanings:

(1) "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(2) "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the organization. "Material professional affiliation" does not include affiliations that are limited to staff privileges at a health facility.

(3) "Material financial affiliation" means any financial interest of more than 5 percent of total annual revenue or total annual income of the organization or individual to which this subdivision applies. "Material financial affiliation" does not include payment by the health care service plan to the organization for the services required by this article, nor does "material financial affiliation" include an expert's participation as a contracting health care service plan provider.

1374.42. (a) Subject to Sections 1374.425 and 1374.426, any party to a noncontracted claim payment dispute may elect to participate in the IDRP by filing a noncontracted claim payment dispute complaint with the organization.

(b) If a noncontracting emergency physician elects to participate in the IDRP, the health care service plan or the health care service plan's contracting risk-bearing organization shall be required to participate. If a health care service plan or its contracting risk-bearing organization elects to participate in the IDRP, the noncontracting emergency physician shall be required to participate.

1374.425. (a) Prior to submitting a noncontracted claim payment dispute to the organization, a health care service plan or its contracting risk-bearing organization shall send an electronic or printed notice to the noncontracting emergency physician stating all of the following:

(1) That the health care service plan or its contracting risk-bearing organization intends to submit the dispute to the organization.

(2) The name and identification number of the noncontracting emergency physician.

(3) The enrollee's name and identification number.

(4) A clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the health care service plan or the contracting risk-bearing organization believes the claim is inappropriate.

(5) A request for adjustment of the claim or other action.

(6) An alternative proposed payment for the service provided, and the specific methodology and database used to calculate that payment.

(b) A health care service plan or a plan's contracting risk-bearing organization may include up to 50 substantially similar disputes in a single notice pursuant to this section if each disputed item is clearly identified and the notice contains the information required by this section. For purposes of this section, "substantially similar disputes" are those that involve the same or similar services or codes provided by the same noncontracting emergency physician.

(c) When a noncontracting emergency physician receives a notice pursuant to subdivision (a), the noncontracting emergency physician may do one of the following:

(1) Within 30 days of receiving that notice, refund to the health care service plan or the plan's contracting risk-bearing organization the difference between the paid amount and the alternative payment proposed pursuant to paragraph (6) of subdivision (a).

(2) Within 30 days of receiving that notice, attempt to negotiate an amount with the health care service plan or the plan's contracting risk-bearing organization that settles the dispute. The noncontracting emergency physician may request additional time from the health care service plan or the plan's contracting risk-bearing organization to complete a negotiation pursuant to this paragraph.

(d) If the noncontracting emergency physician does not make a refund to the plan or the plan's contracting risk-bearing organization pursuant to paragraph (1) of subdivision (c) and the negotiation described in paragraph (2) of subdivision (c) is not completed within 30 days, or the time period granted by the plan

or its risk-bearing organization, the noncontracting emergency physician shall participate in the internal dispute resolution mechanism of the plan or its contracting risk-bearing organization, unless the plan or the risk-bearing organization waives use of that mechanism.

(e) If the noncontracting emergency physician is not satisfied with the outcome of the internal dispute resolution mechanism described in subdivision (d), or if the plan or the contracting risk-bearing organization waives use of that mechanism, the physician shall defend the dispute through the IDRP. The physician shall provide notice to the plan or the plan's contracting risk-bearing organization of his or her intention to defend within 30 days of completion of the internal dispute resolution mechanism or within 30 days of receiving notice that the plan or the risk-bearing organization waives use of that mechanism.

1374.426. (a) Prior to submitting a noncontracted claim payment dispute to the organization, a noncontracting emergency physician shall send an electronic or printed notice to the health care service plan or the plan's contracting risk-bearing organization stating all of the following:

(1) That the noncontracting emergency physician intends to submit the dispute to the organization.

(2) The name and identification number of the noncontracting emergency physician.

(3) The contact information for the noncontracting emergency physician.

(4) The enrollee's name and identification number.

(5) A clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the noncontracting emergency physician believes the payment level or nonpayment of the item is inappropriate.

(6) A request for adjustment of the claim or other action.

(7) An alternative proposed payment for the service provided, and the specific methodology and database used to calculate that payment.

(b) A noncontracting emergency physician may include up to 50 substantially similar disputes in a single notice pursuant to this section if each disputed item is clearly identified and the notice contains the information required by this section. For purposes of this section, "substantially similar disputes" are those that involve

the same or similar services or codes billed to the same health care service plan or contracting risk-bearing organization.

(c) When a health care service plan or a plan's contracting risk-bearing organization receives a notice pursuant to subdivision (a), the health care service plan or the contracting risk-bearing organization may do one of the following:

(1) Within 30 days of receiving the notice, pay to the noncontracting emergency physician the difference between the paid amount, if any, and the alternative payment proposed pursuant to paragraph (7) of subdivision (a).

(2) Within 30 days of receiving the notice, negotiate an amount with the noncontracting emergency physician that settles the dispute. The plan or the plan's contracting risk-bearing organization may request additional time from the noncontracting emergency physician to complete a negotiation pursuant to this paragraph.

(d) If the plan or the plan's contracting risk-bearing organization does not pay the noncontracting emergency physician pursuant to paragraph (1) of subdivision (c) and the negotiation described in paragraph (2) of subdivision (c) is not completed within 30 days, or the time period granted by the physician, the plan or the plan's contracting risk-bearing organization may require the physician to participate in its internal dispute resolution mechanism.

(e) If the plan or the plan's contracting risk-bearing organization does not require the noncontracting emergency physician to participate in the internal dispute resolution mechanism described in subdivision (d), the plan or the plan's contracting risk-bearing organization shall defend the dispute through the IDRP. The plan or the risk-bearing organization shall provide notice to the noncontracting emergency physician within 30 days of determining whether to require the plan to participate in the internal dispute resolution mechanism.

(f) If the noncontracting emergency physician is not satisfied with the outcome of the internal dispute resolution mechanism described in subdivision (d), the noncontracting emergency physician may elect to submit the dispute to the IDRP. The physician shall submit the dispute to the organization within 30 days of completion of the internal dispute resolution mechanism.

1374.43. (a) The organization shall, subject to the department's approval, establish and publish written policies and procedures for receiving and rendering determinations regarding noncontracted

claim payment disputes. These policies and procedures shall include, but not be limited to, a dispute resolution process in which the organization renders a determination of the reasonable and customary value of the health care service or services rendered by applying the standard regarding reimbursement of a claim contained in subparagraph (B) of paragraph (3) of subdivision (a) of Section 1300.71 of Title 28 of the California Code of Regulations. The organization shall apply that standard as it read on January 1, 2007. On or before January 1, 2011, the department shall submit a report to the appropriate policy and fiscal committees of the Legislature on the adequacy and effectiveness of the standard and make recommendations for changes to the standard, if appropriate.

(b) The determination issued by the organization shall include necessary determinations regarding related billing issues, including, but not limited to, appropriate coding and bundling of services. The determination of appropriate coding shall include consideration of the proper intensity of the services that the noncontracting emergency physician provided. The organization shall use the coding and bundling rules under current usage by the Medicare carrier for payment of physician services for California to render those determinations, provided that those rules do not include any reduction in payment for the use of nonphysician health care practitioners described in subparagraph (A) of paragraph (1) of subdivision (d) of Section 1379.1. The organization or the department shall retain claims documentation or coding experts to assist with questions related to claims documentation and coding.

(c) The organization shall not make determinations regarding a coverage dispute between a health care service plan and an enrollee, including, but not limited to, a coverage dispute subject to Article 5.5 (commencing with Section 1374.30). Notwithstanding subdivision (b) of Section 1374.40, a noncontracted claim payment dispute that arises as a result of that coverage dispute shall not be eligible for review by the IDRP unless the coverage dispute is resolved in favor of the enrollee.

(d) Within 60 days following the filing of a noncontracted claim payment dispute complaint with the organization, the organization shall issue its determination regarding that complaint to both the department and the parties to the dispute. Within 15 days following

the issuance of that determination, the nonprevailing party shall satisfy any orders in the determination.

(e) (1) In the determination issued pursuant to subdivision (d), the organization shall choose either of the following:

(A) The noncontracting emergency physician's initial charge.

(B) The initial amount the health care service plan or its contracting risk-bearing organization paid or the alternative proposed payment suggested pursuant to paragraph (6) of subdivision (a) of Section 1374.425 or paragraph (7) of subdivision (a) of Section 1374.426. The alternative proposed payment shall be used in place of the initial amount paid if the health care service plan or its contracting risk-bearing organization paid nothing initially or if the health care service plan or its contracting risk-bearing organization believes that payment at the interim payment standard constituted an overpayment.

(2) The choice described in paragraph (1) shall be based on the preponderance of the evidence submitted and on the amount that more closely reflects the reasonable and customary value of the service or services rendered consistent with the reimbursement standard identified in subdivision (a) of Section 1374.43 and the coding and bundling standard identified in subdivision (b) of Section 1374.43.

(3) The losing party shall be responsible for paying the fee described in subdivision (c) of Section 1374.44.

(f) The department shall seek civil penalties pursuant to Section 1387 if the department finds that the noncontracting emergency physician, the health care service plan, or the health care service plan's contracting risk-bearing organization does either of the following:

(1) Shows a pattern or practice of violating this article.

(2) Engages in a practice that abuses the IDRP.

(g) (1) The department may review the determinations issued by the organization pursuant to this section. The director may assess administrative penalties against a health care service plan, its contracting risk-bearing organization, or a noncontracting emergency physician if the director finds that the plan, the risk-bearing organization, or the physician commits either of the acts described in subdivision (f).

(2) A noncontracting emergency physician, a health care service plan, or a health care service plan's contracting risk-bearing

organization that willfully files false claims, records, or defenses in the IDRP or that engages in a practice of willfully delaying, obstructing, or hindering the IDRP shall be assessed an administrative penalty of the greater of ten thousand dollars ($10,000) or three times the amount of any payments at issue.

(3) A proceeding for the issuance of an order assessing an administrative penalty pursuant to this subdivision shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397.

(h) Nothing in this section shall restrict, impair, or limit the director's authority to suspend, revoke, or otherwise modify a health care service plan's license for engaging in the acts described in subdivision (f).

1374.44. (a) To the maximum extent possible, the organization and the department shall create a simplified, cost-effective process for the resolution of noncontracted claim payment disputes under this article. Requirements for documentation and attachments shall be kept to a minimum. A party to a noncontracted claim payment dispute shall be entitled to submit a written justification of its position to the organization, which shall not exceed 1,000 words.

(b) A party to a noncontracting claim payment dispute may submit to the organization in a single filing a single claim or up to 50 claims that are substantially similar. A party may also require that up to 50 substantially similar claims brought against it by the other party be considered a single filing. For purposes of this subdivision, "substantially similar claims" are those that involve the same or similar services or codes provided by the same noncontracting emergency physician or billed to the same health care service plan or contracting risk-bearing organization.

(c) The department shall establish a fee schedule to pay for the actual aggregate cost of processing disputes pursuant to this article. These fees shall be paid directly to the organization in the manner prescribed by the department. The fees set by the department pursuant to this subdivision shall not exceed the following:

(1) Fifty dollars ($50) for a single claim.

(2) One hundred dollars ($100) for two to 10 claims filed in a single filing.

(3) Three hundred dollars ($300) for 11 to 25 claims filed in a single filing.

(4) Five hundred dollars ($500) for 26 to 50 claims filed in a single filing.

(d) The department may, through the annual budget process, adjust the fees described in subdivision (c) to reflect the cost of processing disputes pursuant to this article.

1374.45. (a) The organization shall collect information about results obtained from the IDRP and shall present the aggregate information collected to the department on a monthly basis.

(b) The department shall collect information about the results obtained from the IDRP and shall report annually to the appropriate fiscal and policy committees of the Legislature. The department shall issue a final report on or before January 1, 2013, regarding all of the following:

(1) The effectiveness of the IDRP.

(2) Whether the operation of the IDRP should be extended.

(3) The impact of the IDRP on emergency safety net providers, reimbursement rates, contracts, and enrollee access to care.

(c) The records of and determinations made through the IDRP shall be made available to the public.

(d) Notwithstanding subdivision (c), the department and the organization shall maintain the confidentiality of any information found by the director to be the proprietary information of the plan, the contracting risk-bearing organization, or the noncontracting emergency physician. The department and the organization shall also maintain the confidentiality of patient information as required under state and federal law.

SEC. 4. Section 1379.1 is added to the Health and Safety Code, to read:

1379.1. (a) A noncontracting emergency physician who provides services at a general acute care hospital shall seek reimbursement for covered emergency medical services provided to an enrollee of a health care service plan solely from that plan or a contracting risk-bearing organization that is financially responsible for the covered emergency medical services rendered under the contract between the plan and the risk-bearing organization. The noncontracting emergency physician shall not seek payment from individual enrollees for those covered emergency medical services, except for allowable copayments and deductibles. A noncontracting emergency physician subject to this section shall have the right to receive reimbursement owed pursuant

to the provisions of this chapter from the plan or the contracting risk-bearing organization that is financially responsible for the covered emergency medical services.

(b) An enrollee who is billed by a noncontracting emergency physician in violation of this section may report receipt of the bill to the health care service plan and the department. A health care service plan that becomes aware that one of its enrollees has been billed in violation of this section shall also report that violation to the department. The department shall take appropriate action against a noncontracting emergency physician upon a determination that the physician has violated this section, including the issuance of a written warning, a cease and desist order, or other actions, as provided in Section 1387.

(c) An enrollee shall have no obligation to pay an amount billed in violation of this section.

(d) For purposes of this section, the following terms have the following meanings:

(1) "Covered emergency medical service" shall have the same meaning as "emergency medical services and care" as defined in Section 1317.1.

(2) (A) Except as provided in subparagraph (B), "emergency physician" means a physician who is employed or contracted with to provide emergency medical services in the emergency department of a general acute care hospital. "Emergency physician" also includes a nonphysician health care practitioner providing emergency services at a general acute care hospital under the supervision of a physician described in this subparagraph.

(B) "Emergency physician" shall not include a physician specialist who is called into the emergency department of a general acute care hospital.

(3) "Noncontracting emergency physician" means an emergency physician, as defined in paragraph (2), who does not have a contract with a patient's health care service plan or the health care service plan's contracting risk-bearing organization to provide health care services to the patient.

(4) "Risk-bearing organization" shall have the meaning set forth in subdivision (g) of Section 1375.4.

SEC. 5. Nothing in this act shall be construed to modify state or federal laws or regulations that prohibit balance billing of Medi-Cal beneficiaries or alter noncontracted rates.

SEC. 6. The Department of Managed Health Care shall take all steps necessary to establish the Independent Dispute Resolution Process identified in Article 5.57 (commencing with Section 1374.40) of Chapter 2.2 of Division 2 of the Health and Safety Code on or before July 1, 2009, and shall issue a declaration to the appropriate policy committees of the Legislature on the date that the process is established. The department shall also post this declaration on its Internet Web site. The department also shall, by regulation, adopt the interim payment standard, as defined in subparagraph (A) of paragraph (2) of subdivision (h) of Section 1371.42 of the Health and Safety Code, by July 1, 2009. The department may adopt emergency regulations to implement this act in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 8. (a) Sections 1 to 5, inclusive, of this act shall become operative when the Department of Managed Health Care adopts the interim payment standard and the Director of the Department of Managed Health Care declares that the Independent Dispute Resolution Process has been established under Section 6 of this act.

(b) Notwithstanding subdivision (a), Sections 1 to 5, inclusive, of this act shall not become operative if the Department of Managed Health Care fails to establish the Independent Dispute Resolution Process or to adopt the interim payment standard by July 1, 2009 as required by Section 6 of this act.

(c) Sections 1 to 5, inclusive, of this act shall become inoperative on December 31, 2013, and as of that date are repealed, unless a

later enacted statute that is enacted on or before December 31, 2013, deletes or extends that date.

Approved _____, 2008

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Governor